

ORIGINAL RESEARCH

Enhancing ethical practice and critical reflection by the sTimul experience in a care ethics lab: Evaluation of the sTimul-experience

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Abstract

Introduction: A three-year European project focused on ethical practice in health and social care. Its key objective was to enhance dignity in care through transformational learning as a result of the sTimul-experience. In the sTimul-experience, health and social care professionals adopted a patients' role for 24 hours, while nursing students provided them care.

Aim: The aim of this evaluation study was to examine and evaluate the sTimul-experience.

Method: A tailored evaluation based on the first and third level of Kirkpatrick's Four Levels of Evaluation of educational programs was defined. Specifically designed questionnaires were completed by participants of the sTimul-experience.

Results: Evaluation-scores varied between a modest satisfaction on the appropriateness of materials provided during the preparation process, to a high satisfaction on coaching during the reflection sessions. The degree the global sTimul experience impacted professional practice scored 7.6. Participants from the UK and France reported highest satisfactory scores. For the majority of the time student-trainers and facilitators worked within the formulated guidelines.

Discussion: After the sTimul-experience, participants reported changes in their personal view on patients situations, underlining the transformative learning in the sTimul-experience. The sTimul-experience broke existing orientations participants had on what it is to be dependent. Participants changed their mental models towards dignity and what is good care.

Conclusion: The sTimul-experience had a serious impact on participants practices. A synthesis of the findings of all the evaluation data clearly demonstrated the relevance of 'a structured and comprehensive preparation', 'the importance of being a simulant by remaining in profile/role', and 'the importance of having different stages of reflection throughout the sTimul-experience'. This paper presents both qualitative as well as quantitative descriptive insights in the evaluation of transformative learning in the sTimul process, whereas until now no publications with a mixed evaluation design exist. Future studies can use our insights in the development of instruments to evaluate transformational learning by simulation in ethics.

Key Words: Dignity in care, Care ethics education, Empathy, Transformational learning, Nursing

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1 Introduction

INTERREG 2 IV SEAS is a European programme promoting cross-border cooperation between the coastal regions of 4 Member States: France, England, Belgium and The Netherlands. Approved by the European Commission in September 2008, the 2 Seas Cross border Operational Programme was allocated a budget of €167 million community funding (ERDF) for the period 2007-2013. Cross border cooperation projects were funded to bring together partners from different countries in the Programme area to develop or solve a shared cross-border issue fitting the priorities of the Programme. The Dignity in Care project aligns with Priority 3; Improving quality of life, and specifically the identified programme operational objective to: Improve the quality of services to the population, including mobility and health care facilities.

Within a three year timeframe between July 2012 and September 2014, and with total budget of €2.663.848, the project aimed to improve the quality of health and social care, by enhancing the ethical practice and critical reflection on dignity in care of health and social care providers in the 2 Seas area. In May 2012, the INTERREG 2 IV SEAS Programme approved the Dignity in Care project. A project management committee and subgroups, comprised of representatives from the 4 partner regions of the INTERREG 2 IV SEAS area, were established. The project partners, KAHO Sint-Lieven, sTimul: care ethic lab in Belgium, Institut Catholique de Lille, ZorgSaam Zeeuws Vlaanderen and HZ University of Applied Sciences in The Netherlands and Partners in Care in the UK, worked together to implement the project plans over a period of three years to its final conclusion in September 2014.

The Dignity in Care project focused on ethical practice in health and social care. Its key objective was to enhance dignity in care through transformational learning in a care ethics lab concept. The project management team established an International Expert Evaluation Group (IEEG), drawn from specialists in each of the partner regions. The primary objective for the IEEG was to evaluate the outcomes of the Dignity in Care project.

Background

Across Europe, dignity is high on the agenda of policy makers, with health policies advocating dignified care for patients in all different kinds of care settings. During the three year Dignity in Care (DIC) project, a number of activities were set up to enhance dignity in care through the ability of ethical reflection and practice by students and care providers in health and social care organisations in the INTERREG 2 IV SEAS region. The overall objective of DIC was to improve dignity and ethics, especially in the care for elderly people and those dependant on care. While the INTERREG 2 IV SEAS Programme had a clear priority to improve the

quality of life and services to the population, DIC was to lead to an improvement in the quality of health and social care in the cross-border region.

Main activity was the sTimul-experience; an improved method of transformational (experience based) learning in a care-ethics lab.^[1,2] The focus in the sTimul-experience was on enhancing knowledge about the dignity and ethics of providing and receiving care. Moreover, the focus was on the experiences of being dependent and being cared for and on the manner in which care was provided; it was about attitude and not about nurses' technical and clinical skills, which were accepted as a basic-necessary.^[3,4] The project build on the experiences in the sTimul-care-ethics labs in Flanders, Belgium, and started a sTimul-experience in The Netherlands. The sTimul-experience offered educational approaches based on transformational learning by experiencing and reflecting. The sTimul-experience provided a simulated care environment wherein health and social care professionals and students experienced over two days and one night the impact of care at first hand.^[2]

The sTimul-experience is a three-phased process, comprising 1) a preparation phase, 2) the actual sTimul-experience and 3) a follow-up phase. In the preparation phase, health and social care professionals and students prepared on their simulation: Professionals chose a role to simulate a patients' situation (and dependency) over two days and one night, whereas the student prepared the nursing (and in a number of sessions also the nutrition) care to be given. The actual sTimul-experience provided a two-day simulation in the fully equipped care environment simulation setting. Health and social care professionals and students experienced for themselves the impact of care, whereas the health care professionals executed the simulation of a care-receivers' situation, and were cared by nurse-students, who took up the simulation of caregivers. An example of a care-receivers' situation is a health care professional that adopted the role of a person with hemiplegia, and simulated dependency needs in various activities of daily living performance. The sTimul-sessions enabled health and social care professionals (care givers) to experience first-hand how it is being cared for and supported in daily living. Adopting the identity and characteristics of a patients' needs for care and support, health and social care professionals moved into a simulated residential 8-bedded care home for a period of 24 hours and became dependent on the care they received: the sTimul-experience. In the follow-up phase, after six weeks, meetings were held wherein participants reflected on their experiences in the sTimul-experience, as well as on the impact of the sTimul-experience on their practices. More (visual) information of the project is to be found at https://www.youtube.com/watch?v=z8j0n2_NGEY. Table 1 provides an overview of the roles of the health and social care professionals and students in the sTimul-experience.

Table 1: Overview of the roles of the health and social care professionals and students in the sTimul-experience.

Origin	Role in the sTimul experience
Health and Social Care professionals.	Simulant care-receiver
Students (Bachelor of Nursing, Bachelor of Nutrition)	Simulant care-giver
Teacher universities of applied sciences	Student-coach
Employee sTimul-lab	Facilitator

The perpetuation of patients' dignity seems important to enable peoples' feelings of empowerment at vulnerable times in their life.^[5,6] Therefore, the concept of dignity is acknowledged as a core aspect of nursing care.^[3,7] A review of the literature showed dignity is represented in a variety of words and seems a complex concept with various attributes. Overall, dignity is about empowering patients by enhancing patients' positive identity and recognize and sustain their own, distinct individuality. Dignity is expressed in the relationships between nurses and their patients.^[3] It is essential that nurses understand the importance of dignity and how to establish and sustain patients' dignity.^[2,3,8] Nordenfelt^[4,5] stated caring and dignity are inseparable. Moreover, Tanner^[6] proposed the importance of nursing is not about health but about respect for human dignity.

In order to uphold dignity, nurses and health care professionals need to emphasize concepts of shared humanity, as a vital component in nursing care.^[9] Nurses' personality and their ability to emphasise a patients' situation are believed to be important aspects of their ability to express dignity. Literature revealed this can be achieved by transformational learning, more specific, by experiencing on what it is to be a patient and to be dependent, and to reflect on these.^[2] Illeris^[10] described transformational learning as a comprehensive type of learning. Transformational learning arises by simultaneous restructuring cognitive, emotional and social/societal perceptions, caused by a (organized) disruption of a persons' mental models. Transformational learning results in changed views or orientations, in this case the changes of one's personal view on the concepts of what is good care and on the concept of dignity in care. The aim of this evaluation study was to examine and evaluate the process and project activity outcomes of the sTimul-experience.

2 Methodology

The initial task of the IEEG was to agree, design and develop the most appropriate and effective tools to gather the data necessary to execute a robust and efficient evaluation program. The IEEG implemented an evaluation strategy that captured the experiences of participants of the sTimul-experience at three stages of the process; 1) at lunch day one, 2) after the reflection day two and 3) after the 6-weeks follow-up meeting. A specifically designed written

questionnaire with closed and open questions, based on the first and third level of Kirkpatrick's Four Levels of Evaluation of educational programs, was defined.^[11] Kirkpatrick's 'four levels' approach evaluates both short-term and long-term educational outcomes.^[11] Level 1 questions were on how satisfied participants were with the different parts of the sTimul-experience (e.g. preparation, reflection sessions etc). The level 3 question was 'to what degree do you think that the global sTimul experience had an impact on your practice?'. In addition, qualitative data were gathered by asking participants to explain their quantitative score. For example, the question 'How satisfied are you with the preparation process?' was directly followed by the question 'why did you gave this score?'. Different questionnaires were applied for students/professionals (A) and student-trainers/facilitators (B) (see Table 2). Analyses were executed to detect mean, minimum and maximum scores and, moreover, differences on the scores related to status and origin of the respondent. All qualitative data were merged per question and a content analysis was performed per region by the regional member of the IEEG. Doing so, the content analyses of the data could be done in native language. Next, the results were translated in English and peer-reviewed by the total IEEG. Finally the peer review led to the presented themes in the three phases of the sTimul-experience. In reporting the results, exemplifying phrases of the participants are presented.

Table 2: Overview data collection.

Questionnaire	Subject of evaluation	Time of data collection
1A	Preparation phase	at lunch day2
2A	The two-day sTimul-experience	after reflection day 2
3A	Follow-up phase	at end of the follow-up session
1B	Preparation phase	at lunch day 2
2B	The two-day sTimul-experience	after reflection day 2
3B	Follow-up phase	at end of the follow-up session

All data were collated and analysed by the IEEG throughout the project. Notwithstanding the language differences and geographic distances involved for members of the IEEG when meeting either virtually or in person to conduct this process, all data have been successfully translated where necessary, analysed, synthesized and finally presented as a comprehensive evaluation of the sTimul-experience outcomes. This study presents both qualitative and quantitative evidence in evaluation of the sTimul process.

3 Results

3.1 Population

Over a period of 3 years (July 2012 - May 2014) in total 28 sTimul-experiences were held in Flanders and The Netherlands. In this activity the initial aim for the cross-border partners was to send more than 250 students and professional care providers from different stakeholders to the care-ethics lab to have the sTimul-experience. In total, 387 (student-) caregivers participated in 28 sTimul-experiences. Evaluation data were gathered from 26 sessions, whereby 157 students and 184 professionals completed evaluation-questionnaires 1A, 2A and 3A. Table 3 reports the characteristics (gender and status) of the health/social care professionals and students that evaluated the Dignity in Care-sTimul sessions. Most respondents originated in The Netherlands (45%). Most respondents were female (88%).

Table 3: Descriptives population (n = 341).

		Frequency	%
Status	Simulant care-giver	184	54
	Simulant care-receivers	157	46
Origin	The Netherlands	153	45
	Belgium/Flanders	79	23
	France	55	16
	UK	54	16
Gender	female	300	88
	male	41	12

3.2 Overview results

Table 4 provides an overview of the mean, minimum and maximum score on all evaluation questions. The mean evaluation-scores varies between 6.8 (how appropriate are the written materials provided during the preparation process) to 8.5 (how satisfied were you with the coaching during the reflection session and how satisfied were you with the coaching during the reflection session).

3.3 Preparation phase

Written training materials have been developed to support the facilitators/student trainers of the sTimul experience. The material was available in Dutch, French and English and disseminated in a three day course following the Launch conference in Flanders. In addition the 1st DVD has been produced in the UK. Participants rated the appropriateness of the written training/preparation materials from 0 to 10. The mean score was 6.8. Scores varied between 0 and 9.

A preparation booklet has also been produced for the simulant care givers and receivers in the project. All participants have been provided with a copy in their native language. This was a generic booklet and therefore not wholly suitable for the nutrition students who took part. Table 5 reports the scores of the satisfaction with the preparation process. Differences in status and origin led to significant differences in scores. Professionals were more satisfied with the preparation phase as students were. Participants of the UK were most satisfied with the preparation phase.

Table 4: Mean, minimum and maximum scores evaluation questions (n = 341)

Questionnaire	Evaluation question	Mean	Min.	Max.
1A	How satisfied are you with the preparation process?	7.4	1	10
	How appropriate are the written materials provided during the preparation process	6.8	0	9
	To what degree did you experience being a care giver/ care-receivers during your sTimul session?	7.4	0	10
	How useful did you find the time out session on day 1?	8.2	0	10
2A	To what degree did you find the reflection session useful?	8.4	1	10
	How satisfied were you with the coaching during the reflection session	8.5	5	10
3A	How useful did you find the follow up meeting?	7.8	1	10
	How satisfied were you with the coaching during the reflection session?	8.5	5	10
	To what degree do you think that the global sTimul experience had an impact on your practice?	7.5	1	10

Qualitative analysis on participants' satisfaction with the preparation process led to four themes: 1) good explanations and organization, 2) objectives have been identified very well, 3) part of the experience was clearly set without too much revealing and 4) fears and apprehensions were cleared.

Exemplifying phrases of simulant care-givers

- I understand how the session will take place and have an idea of the process and also meet the caregiver team. But at the same time I was a little bit worried and have some apprehension.
- The explanation is clear. We received a small diary

with all the necessary information. However, it lacks some information about the role limits and the equipment available in the structure.

- Logistical and practical information were given to us.

Exemplifying phrases of simulant care-receivers

- I think this break on the first day is important: first, to be able to share with the group what we have felt since the morning; able to pass a message to caregivers to continue; it is nice to get rid of our role for an hour.
- The information were timely and relevant. We have a best idea of the experience and we have some testimonials from the previous sessions.
- The preparation gave us an idea of the role that we could play; it was well explained. I had some time to prepare my role as a patient.
- We take the drama out because we gave some explanations, frame(executive) which allows to have some marks.

In addition participants were asked what was the most valuable part of the preparation process? For the simulant caregivers the Organization schedule and explanation of the sTimul-experience came forth. For the simulant care-receivers the most valuable parts of the preparation process were the division of roles, treatment limits (the limit of kind of care liked to be received), and confidence towards the sTimul-experience.

Table 5: Evaluation question ‘How satisfied are you with the preparation process?’

	Mean	Minimum	Maximum	P*
Overall (n = 341)	7.4	1	10	
Simulant care-givers (n = 184)	7.1	0	10	<.001*
Simulant care-receivers (n = 157)	7.8	5	10	
UK (n = 54)	8.7	5	10	<.001**
France (n = 55)	8.3	4	10	
The Netherlands (n = 153)	7.0	4	10	
Belgium/Flanders (n = 79)	6.7	1	9	

* = significance for independent sample t-test; ** = significance for Anova

Exemplifying phrases of simulant care-givers

- Able to share/to discuss with the team and patients
- The most useful part is for me the explanation of the two days, because already I get an idea of the session
- Everything was important in the presentation for an overview: the part of the discussion group on the session organization: careful don't forget the most important

Exemplifying phrases of simulant care-receivers

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- The moment when clarified limits, when we feel confidence/comfortable about the experience. The most important moment was when everybody took into account the specificity of each other. The selected profile must be already defined at this time
- Discussion on roles; already able to play the role
- Building trust with respect to the organization

3.4 Reflection

There were three stages of reflection on the experience and each has been evaluated. Table 6 presents an overview of all three stages.

Table 6: Mean, minimum and maximum scores evaluation questions reflection times during and after the sTimul-experience (n = 341)

Evaluation question	Mean	Minimum	Maximum
How useful did you find the time out session on day 1?	8.2	0	10
To what degree did you find the reflection session useful?	8.4	1	10
How satisfied were you with the coaching during the reflection session	8.5	5	10
How useful did you find the follow up meeting?	7.8	1	10
How satisfied were you with the coaching during the reflection session?	8.5	5	10

Stage 1 – Mid experience

When asked how useful the Time-Out session on day one of the two-day experience was, the mean score was 8.2 out of a maximum of 10 – clearly a valuable time for the participants to share feelings, anxieties and relax out of role/profile, which some found exhausting. Many found this to be a useful time to provide and receive feedback. It provided a pivotal point for care givers to alter their approaches. Table 7 presents the degree of usefulness participants that rated for the time out session on day 1. Differences in status did not lead to significant differences in scores. Origin of the participants did lead to differences in scores, whereas French participants rated highest mean scores to the usefulness of the time out session on day 1.

Participants were asked what they thought the most important aspect of the time out session on day one. Three important topics concerning the usefulness of the time out on day one evolved: 1) having a moment for reflection, 2) have a break and 3) sharing feelings.

Exemplifying phrases of simulant care-givers

- This allows you to see where we are, what we think; experienced colleagues of the team; This could be improved; having a break.
- The most Essential is to share our emotions, our

thoughts.

- The time out able to decompress, to share our feeling immediately
- Experience that care givers do their best to make it comfortable for you while it doesn't land that way, and this on different levels: physical care, care for the meals, psychological care."
- Vital to have a break, to just feel normal again, and back in control even for just an hour.

Table 7: Evaluation question 'How useful did you find the time out session on day 1?'

	Mean	Minimum	Maximum	P
Overall (n = 341)	8.2	0	10	
Simulant care-givers (n = 184)	8.0	0	10	.084*
Simulant care-receivers (n = 157)	8.4	1	10	
France (n = 5)	8.9	5	10	
UK (n = 54)	8.0	0	10	
Belgium/Flanders (n = 79)	8.5	0	10	.002**
The Netherlands (n = 153)	7.9	2	10	

* = significance for indepent sample *t*-test; ** = significance for Anova

Exemplifying phrases of simulant care-receivers

- I think this break on the first day is important: first, to be able to share with the group what we have felt since the morning; able to pass a message to caregivers to continue; it is nice to get rid of our role for an hour.
- It allows you to pass a message, exchange with care recipients.
- It is very important because it helps to have a break, change our minds; discuss our experiences, our feelings
- Very fascinating, one knows in that way what the care-receiver is thinking, how he feels
- Good moment to speak up about unclarities and experiences so that behaviour/situation can be modified

Stage 2 – End of 2 day experience

All participants took part in reflection sessions at the end of the two-day experience. Personal feedback was given in small groups/pairs and whole group reflection was facilitated by the stimul coach. When asked to what degree the reflection session at the end of day2 was, the mean score was 8.4 out of a maximum of 10. Participants rated their satisfaction with the coaching during the reflection-session from 0 to 10. The mean score was 8.5. Scores varied between 5 and 10. These sessions afforded time for deeper reflection of personal practice. Participants were often tired at this stage and emotional. Reflection provided the opportunity for pro-

fessionals to consider their usual practice. The role of the facilitator seemed crucial in supporting these sessions.

Table 8 presents the degree of usefulness participants rated for the reflection session. Differences in status did not lead to significant differences in scores. Origins of the participants led to differences in scores. French participants rated highest mean scores to the usefulness of the reflection session.

Table 8: Evaluation question 'To what degree did you find the reflection session useful?'

	Mean	Minimum	Maximum	P
Overall (n = 341)	8.4	1	10	
Simulant care-givers (n = 184)	8.2	1	10	< .068*
Simulant care-receivers (n = 157)	8.7	5	10	
France (n = 5)	9.3	6	10	
UK (n = 54)	8.8	6	10	
Belgium/Flanders (n = 79)	8.5	1	10	< .001**
The Netherlands (n = 153)	8.0	2	10	

* = significance for independent sample *t*-test; ** = significance for Anova

For the participants the most relevant elements during the reflection are, on one hand, the experience sharing and the exchange and, on the other hand, the understanding of the patient and the good care.

Exemplifying phrases of simulant care-givers

- The feedback has allowed me to write useful words for the final reflection with the group and think to research ideas on ethics in the curriculum.
- Communication between caregivers and care-receivers for, have feelings on both sides, makes you aware of some things that we had not necessarily noticed or that we did not pay attention, consider the person in whole.
- Importance of communication between caregivers and patients, the first thing you see is not necessarily what we think.
- Being able to offload some of the extraordinary complex emotions before we leave the safety of sTimul.
- The effect of the reflection is that everybody knows what is going on in the thoughts of the others. Perceptions are shared.

Exemplifying phrases of simulant care-receivers

- Express the experience feelings, review and reflect on professional practice, learn, pay attention on authenticity in the care.
- Knowing what was good to do or not; able to question our attitudes.

- Reflection on the meaning of life for a dependent person: what prospects;? notion of listening and time.
- To hear about the experiences of the care receivers: being tired, being anxious, having lost your autonomy. And the fact that they never learned to relieve to this feelings.
- The feedback of the care-receiver is important. Some of my good intentions are not received positively.

Stage 3 – Follow-up meeting at 6 weeks

At these sessions—students and professionals mostly met separately. Here the reflection was broaden into wider discussions about professional practice. There have been requests from the two groups to remain in contact and this was supported by the project web platform. When asked how useful the follow up meeting was, the mean score was 7.8 out of a maximum of 10. Participants rated the satisfaction with the coaching during the follow-up meeting from 0 to 10. The mean score was 8.5. Scores varied between 5 and 10. Table 9 presents the degree of usefulness participants that rated the follow-up session. Differences in status did lead to significant differences in scores. In addition, origin of the participants led to differences in scores. Participants of the UK and Belgium rated highest mean scores to the usefulness of the follow-up meeting.

Participants rated the post-session evaluation as important, as it afforded time to reflect on the experience and their feelings. The post-session also provided an opportunity to share experiences in providing good care. Therefore, it was able to promote listening, speaking, sharing feelings and experiences between patients and caregivers. Then, new ideas and thoughts could emerge. Simulant care-givers and simulant care-receivers agreed on the fact that the most significant element of the reflection session after the sTimul-experience was sharing experiences.

Table 9: Evaluation question ‘How useful did you find the follow up meeting?’

	Mean	Minimum	Maximum	P
Overall (n = 341)	7.8	5	10	
Simulant care-givers (n = 184)	7.1	1	10	.002*
Simulant care-receivers (n = 157)	8.1	5	10	
UK (n = 54)	8.4	8	10	
France (n = 5)	8.4	6	10	
The Netherlands (n = 153)	7.7	5	10	<.001**
Belgium/Flanders (n = 79)	7.6	1	10	

* = significance for independent sample *t*-test; ** = significance for Anova

Exemplifying phrases of simulant care-givers

- The time is large enough, having a time before between caregiver and a common time helped to high-

light important ideas

- Is not necessarily to talk about the same topics during the session, for example we noticed new aspects
- Talking about his professional experience after sTimul, the changes that they have created in our practice
- Confirmation of the contribution to meaning and dignity of others by our way of acting. To ‘see someone as a person’, ‘to acknowledge someone’, by all little aspects of caregiving
- My feelings and learning have changed since returning, if anything they have deepened and become clearer

Exemplifying phrases of care receivers

- Interaction with caregivers.
- Sharing our feelings.
- The revelation of shared concerns, questions inter-linked
- I find the most interesting what you take with you for practice, what you now do different from the past. What are you (unconsciously) going to see as more important

Table 10: Evaluation question ‘To what degree did you experience being a caregiver/ care-receivers during your sTimul session?’

	Mean	Minimum	Maximum	P
Overall (n = 341)	7.4	0	10	
Simulant care-givers (n = 184)	7.2	0	10	.057*
Simulant care-receivers (n = 157)	7.6	4	10	
UK (n = 54)	8.4	0	10	
Belgium/Flanders (n = 79)	7.5	0	10	
The Netherlands (n = 153)	7.3	3	10	<.001**
France (n = 55)	6.6	1	10	

* = significance for independent sample *t*-test; ** = significance for Anova

3.5 Impact of the sTimul-experience

A key concept of the sTimul experience was taking on a role (as a care giver) or profile (as a care receiver) for a significant period of time. This created a unique opportunity to learn through experience. The extent of this realism was therefore crucial to the impact of the learning experience. The responses to the question “ To what degree did you experience being a care giver/care-receivers during your sTimul session?” were scored from 0 to 10, where the mean score of 7.4 clearly demonstrated the authenticity of the experience. It is interesting to note that the simulant care-receivers scored the experience higher than the simulant care-givers at 7.6. The extent of the realism seemed

to have been affected significantly for the simulant care-givers by the degree to which the care receivers remain in profile. Table 10 reports the degree wherein participants experienced being a caregiver/ care-receivers during their sTimul-experience. Respondents originating in the UK were most positive in their experience of being a simulant in the sTimul-experience.

The participants explained their score by a mix of individual and contextual factors. As individual factor the participants described the ability to adopt a depending profile; can (and wants) one undergo dependency and, for example, be washed by the simulant care-givers. This ability is influenced by the context of the sTimul-experience. If other participants were convincing in their simulation-role-playing the entire simulation was enhanced. Providing a simulation context gave simulant care-receivers the physical and environmental facilities to adopt their role. Still, without collective effort, wherein both the simulant care-receivers and simulant care-givers roles were well expressed, it was difficult to start and sustain the simulation.

Exemplifying phrases of simulant-caregivers

- From the beginning of the experiment, care recipients are quickly played their role which helped me to immediately get involved in the caregiving role. The work dress and the local help us to identify our role.
- Sometimes we went out of our role, for example during collective laughter because sometimes during the bed bath moment we don't know how far should we go/do. In other words, the person playing the role defines their limits
- Through the construction of my profile of care-receiver, and by observing the occupant, I came to a closer relationship with this person, and a better insight of his limitations, needs and necessities. Realizing that for me, this is only a role play, while it could be the hard reality and that me too I could be one day someone who asks for care."

Exemplifying phrases of simulant care-givers

- Difficult to be all the time in the role but on short time it's easier; group effect is stimulating.
- Creativity throughout the day in connection with the character; discoveries about themselves and others; difficult to stay focused on our role after 4 hours.
- simulant care-receivers.
- I am in D2, it is my first training course of extern. Thus it is very difficult to play the role of doctor and get decisions. I have no experience as a nurse or nurse's aide.
- The better the role was played the easier it was. With some people I even forgot it was even a simulation.
- Makes you stand still, surprise, doing new things or old things in a new way.

Table 11 presents the degree in which the sTimul experience had an impact on participants' professional practice. When asked to what degree the global sTimul experience would impact their professional practice, the mean score being 7.6. Differences in status did not lead to differences in scores. Origin of the participants did lead to differences in scores. Participants of the UK and France rated highest mean scores.

Table 11: Evaluation question 'To what degree do you think that the global sTimul experience had an impact on your practice?'

	Mean	Minimum	Maximum	P
Overall (n = 341)	7.6	1	10	
Simulant care-givers (n = 184)	7.6	4	10	.781*
Simulant care-receivers (n = 157)	7.5	1	10	
UK (n = 54)	8.2	8	10	<.001**
France (n = 55)	8.2	5	10	
Belgium/Flanders (n = 79)	7.6	4	10	
The Netherlands (n = 153)	7.1	1	9	

* = significance for independent sample t-test; ** = significance for Anova

Participants were asked whether they would recommend the sTimul experience to others. Simulant care-givers and simulant care-receivers recommended the experience because it allowed questioning practices and provided new information. Then, for them there is a real impact on their practice

Exemplifying phrases of simulant care-givers

- This is a personal and professional enrichment.
- This experience is very rewarding and allows us to question our practice and some themes such as death, pain; it allows us to point our limits in the relationship.
- This experience can be challenging; show the importance of ethics in our practices.

Exemplifying phrases of simulant care-receivers

- You can develop your vision on care.
- I think when you live this experience you are more aware and will develop a different approach.

3.6 Results evaluation student-coaches and facilitators

3.6.1 Population

To catch the perspectives of the student-trainers and facilitators, specified evaluation questionnaires were developed. In total, 44 evaluation-questionnaires were completed. Table 12 provides the characteristics of the population that responded to the evaluation questionnaires.

Table 12: Population evaluation questionnaire B; student-coaches (n = 25) and facilitators (n = 19)

	Questionnaire 1B & 2B	
	N	%
Status		
Student coach	25	57
Facilitator	19	43
Gender		
female	30	68
male	14	32

Student coaches and facilitators were asked whether or not the guidelines were followed, added or omitted anything to the session or intervened in the actual sTimul experience. In addition, the student trainers were asked to rate the degree of usefulness of the reflection session after the actual sTimul and to write down valuable elements during the reflection and the degree they felt equipped to lead the post-sessional evaluation.

Table 13 reports the scores of the student-trainers/ facilitators on the evaluation questions. All, but one, respondents followed the guidelines of the preparation-phase. Eleven respondents intervened in a session, six times student-

trainers, five times the facilitators. Student-trainers rated the evaluation-question on the degree they felt equipped to lead the reflection session with 6.8 on a scale of 0 -10. Facilitators rated this question with 6.4.

4 Discussion

The aim of this evaluation study was to examine and evaluate the process and project activity outcomes of the sTimul-experience. Therefore, the IEEG implemented a specifically designed written questionnaires, based on the first and third level of Kirkpatrick's Four Levels of Evaluation of educational programs[11], which was completed by sTimul participants at three stages of the process. Overall, the evaluation-scores on Kirkpatrick's first level of evaluation (satisfaction towards the program) varied between a modest satisfaction on the appropriateness of the written materials provided during the preparation process to a high scores on their satisfaction with the coaching during the reflection session and with the coaching during the reflection session. When asked to what degree the global sTimul experience would impact their professional practice, Kirkpatrick's third level of evaluation, the mean score was 7.6. There were no significant differences in the scores of caregivers and students. Participants from the UK and France reported the highest satisfactory scores.

Table 13: Overview scores evaluation questions Student-coaches (n = 25) and Facilitators (n = 19)

Questionnaire	Evaluation question	Status	yes	no	P	
1B	Did you follow the guidelines	student-trainer	24	1		.357*
		facilitator	19	0		
	Did you have to intervene in the sTimul-session	student-trainer	5	19		< .001*
		facilitator	6	13		
Questionnaire	Evaluation question	Status	Mean	Min.	Max.	P
2B	To what degree did you feel you were equipped to lead the reflection session	student-trainer	6.8	5	8	.005**
		facilitator	6.4	5	8	
	How satisfied were you with the coaching during the reflection session	student-trainer	8.7	6	10	.053**
		facilitator	8.5	5	10	
3B	If you led the reflection session, to what degree did you feel you were equipped to lead the session	student-trainer	-	-	-	-
		facilitator	9	9	9	
	to what degree did you feel equipped to lead the post-sessional evaluation	student-trainer	-	-	-	-
		facilitator	6.7	4	8	

* = significance for Chi-square; ** = significance for independent sample *t*-test;

The sTimul-experience aimed to enhance dignity in care by letting (student) nurses and health care professionals experience the impact of being a patient. After the sTimul-experience, participants reported changes in their personal view on patients' situations, which underlines the transformative learning in the sTimul-experience. Illeris^[10] il-

lustrated that creating special situations led to restructured mental models, by adjusting cognitive, emotional and even social-societal aspects of, in this case, the way people view patients' situations. The sTimul-experience broke existing orientations participants had on what it is to be a patient and to be dependent.^[2] Moreover, the participants changed

views or orientations on the concepts of what is good care and dignity in care. The findings in this evaluation study show the sTimul-experience enforced the empathic abilities of the students and care providers who took part in the sessions. Almost all participants stated in the reflection sessions they were affectively influenced by their experiences. Participants reported feelings of being dependent, shamed, humiliated, ignored, and under-empowered when being cared for by the students. Because the students heard these reflections, they started to realize the impact of caregiving. In line with findings of Van Laere *et al.*,^[2] it were especially the statements about being affectively influenced in the reflection-sessions that made participants realize what it is to be a patient and provided insights into the situations and feelings patients go through. The reflection started as self-reflection on situations and experiences in the sTimul-experience, but in the reflection-sessions they led insight into participants' own ethical awareness. Because the reflection-sessions were not about ethical theories or concepts, participants started to realize their own changes in mental models towards dignity and the need of their abilities to emphasize a patients' situation as important aspects to enhancing dignity. Still, not all participants reported changed perspectives. For a successful sTimul-experience, wherein transformative learning arose and reflection led to expressing experiences and thoughts/views on dignity and what is good care, it seemed important that participants remained in their role as simulants throughout the entire sTimul-experience. This differed per group of participants, sometimes either simulant-caregivers or simulant care-receivers broke with their role. Therefore, eleven times the coaches had to intervene in the sTimul-experience. The findings in this evaluation study, however, did not provide answers to the cause of these differences between groups.

Participants rated positive scores on the impact of the sTimul-experience on their practice, but, questions remains how sustainable the impact is, and on how to enforce the sustainability of the sTimul-experience. In the follow-up phase, participants rated the degree of impact of the sTimul experience on their professional practice. Sometimes, rudimental changes were noted, e.g. on meal supplement or reframing day-schedules for patients to avoid empty hours during the day. Also more in-depth changes were noted, e.g. adjusted behaviour and development of skills that show better understanding of patients. Still, we do not know what influences the sustainability of the changes participants reported. Therefore, questions about how to raise the effect on clinical practice and enhance dignity in care remain. Participants, as well as everyone who hears about the sTimul-experience, are very enthusiastic. There are, however, still only two sTimul-houses. Moreover, besides the partner-organizations in the project, not many organizations are willing to train their staff in the sTimul-experience.

In the present evaluation study, we opted for a mixed de-

sign, collecting quantitative and qualitative data to gather insights in participants' experiences during the sTimul-experience. A weakness of the study was that there was no standardized measurement instrument available. Therefore the IEEG composed specifically designed written questionnaires, which strongly reduced the external validation of the findings. Another weakness was that not all participants completed the questionnaires, which may have left out experiences. Still, this study should be considered as an evaluation study with a pragmatic approach.

The strength of this study is that the study was composed and supervised by an international evaluation expert group. Mingling different (international) expertise led to a comprehensive design and evaluation strategy. The IEEG regularly and closely monitored the collection, as well as the analyses and thoroughly discussed the evaluation findings.

5 Conclusions

In the DIC project, the sTimul-experiences provided participants a two-day simulation in a fully equipped care environment. Over a period of three years a total of 28 sTimul-experiences were held in Belgium and The Netherlands. Health and social care professionals and students experienced for themselves the impact of care by taking on the profiles/roles of simulant care-receivers or simulant caregivers. The initial aim for the cross-border partners was to send in total more than 250 students and professional care providers from different stakeholders to the care-ethics labs to participate in the sTimul-experience. Far exceeding this aim, a total of 387 actually participated in the experience, from which 314 participants took part in this evaluation.

Overall, participants' perspectives on the evaluation questions were positive. A synthesis of the findings highlighted the importance of a 'structured and comprehensive preparation', 'the importance of being a simulant by remaining in profile/role', and 'that it is crucial to have different stages of reflection throughout the sTimul-experience'. The sTimul-experience had a serious impact on participants practices.

Overall, the key outcomes of the evaluation process are:

- (1) Structured and comprehensive preparation of the sTimul experience is important
- (2) Remaining in profile/role impacts on the value of the experience.
- (3) Different stages of reflection throughout the experience are crucial
- (4) The exchanging of experiences and good practice via cross border and regional networking has enhanced the dissemination and implementation of dignity in care.
- (5) Despite the differences in cultural and national settings DIGNITY is about personal attention and relationship.

- (6) Large dissimulation of information and experiences has found place of the sTimul concept during the Dignity in Care project.

In setting up the DIC project, an evaluation strategy was composed to explore the outcomes of the project. Based on the first and third level of Kirkpatrick's Four Levels of Evaluation of educational programs, targeted instruments were designed. The rigor of setting up and executing a research design was never pursued, whereas this study should be considered as an evaluation study with a pragmatic approach. This may hinder the validity of the reported results, but not of the project. Moreover, this paper presents both qualitative as well as quantitative descriptive insights in the evaluation

of transformative learning in the sTimul process, whereas until now no publication with a mixed evaluation design exists. Future studies can use our insights in the further development of the evaluation of transformational learning by simulation in ethics.

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Conflicts of Interest Disclosure

The author declares that there is no conflict of interest statement.

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